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Reproductive health for conflict-affected people

Policies, research and programmes

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In brief

• This paper aims to equip humanitarian practitioners with essential information for delivering effective reproductive health services to people in crises.

• Over the past decade, significant progress has been made in developing a capacity to respond to reproductive health needs in emergencies.

• Substantial gaps in programme coverage, content and quality remain, making it difficult or impossible for affected populations actually to obtain reproductive health services. There is a paramount need to address the issue of equity between refugees and the internally displaced, forced migrants and host populations, men and women, adults and adolescents.

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Chapter 1
Introduction

The humanitarian community first became aware of the reproductive health needs of refugees and other war-affected people during the ethnic conflicts in Bosnia and Rwanda in the early to mid-1990s. Since then, significant progress has been made in developing a capacity to respond to reproductive health needs in emergencies. This paper describes advances in policy; outlines what we know about the magnitude of reproductive health needs; and explores the lessons for programming. It aims to equip humanitarian practitioners with essential information for delivering effective reproductive health services to people in crises.[1]

A maternity ward in the Democratic Republic of Congo

What do we mean by 'reproductive health'?

The Programme of Action agreed by 179 countries at the Cairo Conference on Population and Development in 1994 defines reproductive health as follows:

> *a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.*[2]

It is the obligation of health providers to deliver services that support reproductive health. In crisis situations, the focus is primarily on four areas:

- *Safe motherhood* – preventive and treatment services to support healthy mothers and healthy babies.
- *Family planning* – to permit people affected by crises to implement their reproductive decisions.
- *STI/HIV/AIDS* – services that reduce transmission and offer care for infected people.
- *Gender-based violence* – protection and response to meet the needs of vulnerable populations.

Why should a humanitarian response include reproductive health interventions?

Three main reasons compel humanitarian responders to address reproductive health issues.

First, reproductive health is part of the right to health. Three bodies of international law form the framework to address the needs and rights of people affected by emergencies. *Human rights law* encompasses the international human rights standards – outlined in the Universal Declaration of Human Rights and other human rights documents – that apply to all people, including the displaced. *Refugee law* is rooted in the Convention on the Status of Refugees and its Protocol, treaties that set out responsibilities for the provision of social services for refugees. *Humanitarian law* describes the rules of war and has specific language about the treatment of non-combatants and the protection of children and women from harm. Gender-specific provisions of humanitarian law have been strengthened by affirmations of rape as a specific war crime and as an element of other international crimes by the international tribunals associated with conflicts in the former Yugoslavia and in Rwanda.

Second, reproductive illness is a significant public health issue. The World Bank has estimated that 36% of disability-adjusted life years lost for women in developing countries in 1990 was caused by reproductive illnesses, especially maternity-related causes. In the same year, 12% of men's disability-adjusted life years lost was due to reproductive illness, primarily sexually-transmitted infections and HIV/AIDS.[3] Until recently, there were no data to describe the scope of the reproductive needs of emergency-affected populations; however, a section of this paper is devoted to just such a description. This information can be used to guide humanitarian reproductive health programming and,

with project-generated data, can demonstrate programme effectiveness.

Third, reproductive health services are part of the protection obligations of states and humanitarian agencies. In the Sphere Project's Humanitarian Charter, aid agencies reaffirm their conviction that all possible steps should be taken to prevent or alleviate human suffering arising out of conflict or calamity, and that civilians so affected have a right to protection and assistance.[4] While state authorities are the primary duty-holders responsible for protecting people, humanitarian intervention is appropriate when state actors are unable or unwilling to perform this function. Services in support of reproductive health protect and assist in just such situations.

What reproductive health services should be available to conflict-affected people?

The Inter-agency Working Group on Reproductive Health in Refugee Situations, a group of relief and development agencies coordinated by the UN High Commissioner for Refugees (UNHCR), developed a Minimum Initial Service Package (MISP) for basic reproductive health care in the early phase of a humanitarian emergency.[5] MISP requires planners to:

- Identify an onsite organisation and individual to coordinate MISP activities
- Prevent and manage the consequences of sexual violence by:
  - Ensuring the protection of conflict-affected populations
  - Providing medical care, including emergency contraception
- Reduce HIV transmission by:
  - Enforcing respect for universal precautions, including use by health care workers of protective barriers to prevent exposure to blood or other body fluids
  - Guaranteeing the availability of free condoms
- Prevent excess neonatal and maternal morbidity and mortality by:
  - Providing clean delivery kits for use at home
  - Providing midwife delivery kits for use at health facilities
  - Initiating a referral system to manage obstetric emergencies
- Plan for the provision and monitoring of comprehensive reproductive health services integrated into primary health care.

The manual goes on to describe what comprehensive services entail. Essentially, the following reproductive health programmes are recommended:

- support for safe motherhood;
- access to family planning;
- control of STD/HIV/AIDS; and
- prevention of, and response to, gender-based violence.

Who are the conflict-affected?

Early reproductive health programmes in conflict settings primarily addressed the needs of refugees in stable camp settings. Of the nearly 35 million displaced people around the world, however, only 13m have crossed an international border to gain refugee status; another 22m are internally displaced.[6] As the field has evolved, organisations have recognised that IDPs, host populations and others who may not be displaced but who are otherwise affected by armed conflict also have unmet reproductive health needs. In addition, ethical considerations demand that organisations address the issue of denying (often superior) services provided for the displaced to the surrounding host population.

Chapter 2
Reproductive health and the humanitarian agenda

Before the early 1990s, there were no humanitarian 'reproductive health' services as such. Humanitarian relief health programmes serving refugees were designed to address maternal and child health (known by the acronym MCH), with an emphasis on the health of the woman only in regard to her contribution to the health of the child. Clinics generally provided ante-natal care and some assistance for delivery, and some sites also offered post-partum care and family planning. Gender-based violence was seen as an issue of refugee protection, with only limited links to health services for the provision of clinical care to victims of sexual assault. Before the onset of the AIDS pandemic, sexually-transmitted infections were almost exclusively the responsibility of curative health services, and were frequently relegated to an odd clinic on an odd day. Humanitarian agencies working with refugees focused on the prevention of excess mortality through the provision of food, water, shelter and basic health care.

By the early 1990s, this had begun to change. In 1990, the UNHCR issued a 'Policy on Refugee Women and International Protection'. This stated as essential the full participation of refugee women in all aspects of humanitarian programming, including health services, and made clear the agency's obligation to deter, detect and redress physical and sexual abuse.[7] It was not, however, specific about reproductive health services. To help integrate this policy into its programming practice, the agency also issued guidelines on the protection of refugee women, and a planning tool, 'People-Oriented Planning at Work'.[8] UNHCR's 1994 document 'Refugee Children: Guidelines on Protection and Care', based on the Convention on the Rights of the Child, offers support for programmes to reduce children's vulnerabilities in crisis situations.[9] This was one of the earliest documents to call for trained psychologists to assist survivors of sexual violence and for family planning, as part of MCH care.[10]

Three other interventions were crucial to the emergence of reproductive health as a humanitarian concern in the early 1990s. The first, in 1993, was an editorial in the British medical journal *The Lancet*, which argued strongly in favour of the provision of such services: 'It is not offering choices,' the journal stated, 'that is reprehensible.'[11] The following year, US NGO the Women's Commission for Refugee Women and Children conducted a landmark study uncovering the dearth of reproductive health care available to displaced populations.[12] Finally, the UN International Conference on Population and Development (ICPD) in Cairo in 1994 defined sexual and reproductive health care and recognised the specific reproductive health needs of refugees and internally displaced people.

The impact of the Cairo Conference on Population and Development

UN agencies including UNHCR, governmental agencies and international NGOs active in humanitarian assistance all reacted vigorously to Cairo's call to action. Supported by dedicated funding and propelled by activist staff, guidelines, training manuals and field tools were produced to enable agencies to implement reproductive health programmes as a standard part of humanitarian response. At the same time, policy statements became more specific about the obligation to address reproductive health issues, along with other causes of morbidity and mortality in emergency settings.

Concrete expressions of this new commitment quickly emerged. Early in 1995, five international NGOs – CARE, the International Rescue Committee, the JSI Research and Training Institute, Marie Stopes International and the Women's Commission for Refugee Women and Children – formed the Reproductive Health Response in Conflict Consortium to promote sustained access to comprehensive, high-quality reproductive health care in emergencies, and to advocate for policies that support the reproductive health of people affected by armed conflict.[13] In 1998, the Consortium expanded to seven members with the addition of the American Refugee Committee (ARC) and the Heilbrunn Department of Population and Family Health at Columbia University. In June 1995, UNHCR and the UN Population Fund (UNFPA) agreed to collaborate in addressing the needs of displaced populations for reproductive health information and services. The *ad hoc* Interagency Working Group on Reproductive Health in Refugee Situations emerged in 1995 out of a series of consultative meetings on reproductive health in conflict settings co-hosted by UNHCR and UNFPA. In 1999, 33 agencies from the government, the UN and the NGO sector endorsed the guidance offered in the Working Group's *Interagency Manual on Reproductive Health in Refugee Situations*. Although compliance with the manual's provisions remains voluntary, formal endorsement by so many important actors in the reproductive health and humanitarian fields has given it a high profile and quasi-normative status. The 2004 revision of the Sphere Charter and Minimum Standards in Disaster Response includes a standard on the provision of reproductive health services to populations affected by emergencies. This is an important change from the original guidelines of 2000, where reproductive health was included only in a guidance note in the health services section.

For all this undoubted progress, agency-specific policies on the provision of reproductive health services in humanitarian response have been somewhat limited. In September 2000, a study of US-based international NGOs

Box 1

Reproductive health and HIV/AIDS

HIV/AIDS constitutes an important component in the overall approach to reproductive health in emergencies. Because of the stigma associated with HIV/AIDS and in order to protect conflict-affected populations, policies on HIV/AIDS have developed independently of other reproductive health issues. As early as 1988, UNHCR issued guidelines aimed at protecting refugees from HIV screening before entry into another state. In 1992, the agency issued a statement of policy and guidelines regarding refugee protection and AIDS, which said that refugees should not be subject to mandatory HIV testing. Other agencies, both within the UN and elsewhere, have issued their own reports, policy statements and guidelines, many of which apply to conflict situations.[14] In 2003, for example, the Interagency Standing Committee, which coordinates humanitarian response across UN agencies, issued its 'Guidelines for HIV/AIDS Interventions in Emergency Settings', providing direction on how the humanitarian community should control HIV/AIDS among populations affected by emergencies.

NGOs have also increased their attention to HIV/AIDS in conflict settings, and are beginning to move beyond the mere provision of HIV education and free condoms to providing voluntary counselling and HIV testing (VCT), prevention of maternal to child transmission and anti-retroviral therapy. The American Refugee Committee and the International Rescue Committee, for example, successfully piloted an HIV prevention programme in southern Sudan that introduced VCT along with improved care and treatment for STIs.[15] Such interventions are necessary and should become the norm rather than the exception for conflict-affected populations. New resource and training materials have been developed to this end. As one example, the International Rescue Committee has published *Protecting the Future*, a manual for health workers designing comprehensive HIV programmes for war-affected populations;[16] the Reproductive Health Response in Conflict Consortium (RHRC) was in 2004 preparing a training manual on HIV/AIDS and STIs for humanitarian workers.

conducted by the Women's Commission for Refugee Women and Children revealed that, of 33 agencies surveyed who provided reproductive health services to displaced populations, only eight had a policy or guidelines covering reproductive health for refugees.[17] Preliminary findings from a similar study in 2004 indicate that 12 of 30 agencies surveyed currently have a policy on reproductive health in conflict, the majority adopted since 2000.[18] That said, while having a specific articulated policy may be advantageous, the lack of one should not be taken to indicate a lack of commitment to reproductive health for conflict-affected populations. Indeed, the studies showed that, even without internal policies specific to reproductive health, agencies were providing reproductive health services.

The resources made available for reproductive health programming in humanitarian response also increased after Cairo.[19] Although precise figures are unavailable, funding for reproductive health programming in emergency situations increased steadily from 1994 to 1999, supporting new and upgraded reproductive health programmes in both new and old relief settings. For example, funds were made available for supplies and services to address the reproductive health needs of Kosovar refugees; Pakistan's Northwest Frontier

Box 2

Marie Stopes' reproductive health kits in the former Yugoslavia

In 1994, Marie Stopes International (MSI) developed the first Reproductive Health Kits for conflict-affected people in the Former Yugoslavia. MSI distributed 78 kits containing medical supplies, drugs and equipment to 47 health institutions in Bosnia. The kits, which were well-received by health professionals and international NGOs in Bosnia, allowed hospitals and health centres to re-establish essential reproductive health services. Monitoring enabled the project to review and refine the composition of the kit and to provide supplementary supplies and equipment to meet specific needs.[20] These kits, later developed and adapted, are seen as the forerunners of the Minimum Initial Services Package (MISP) and UNFPA's pre-packaged reproductive health kits, which provide essential drugs, equipment and supplies designed specifically to facilitate the implementation of reproductive health services in the early phase of a crisis.

Province, which hosted more than a million Afghan refugees, received new support for a variety of reproductive health interventions.

Since the turn of the millennium, specific funding for reproductive health programming has been less readily available. There appear to be three major reasons for this. First, the Bush administration in the US (the US has always been the largest funder of reproductive health programmes) has reduced the amount of funding available for reproductive health. On his first day in office in 2001, Bush reinstated limitations on US development funding to overseas organisations providing reproductive health services.[21] Two years later, these restrictions were extended to cover funding for emergency response.[22] The US government has, however, continued to support programming in the area of gender-based violence. Second, private foundations which had supported reproductive health programming lost significant amounts of capital in the stock market decline during this period, and reduced their grant-making accordingly. Third, it appears that some money which might have gone to general reproductive health programming has been diverted to specific HIV programming. Recent programming trends show that relief agencies are incorporating some reproductive health services into basic health programming, while programmes for gender-based violence and HIV control tend to be seen more as special, stand-alone interventions.

Chapter 3

Conflict, displacement and reproductive health

This chapter looks at the impacts of war and displacement on the reproductive health of conflict-affected people. It is necessarily provisional. This is partly a function of the relative youth of this area; the fact that interventions around reproductive health are barely a decade old means that the empirical evidence on which programming decisions can be based is not as robust or as accepted as in other, more long-standing areas of intervention. The link between conflict and fertility and family planning, for example, cannot be easily quantified and explained, and the relationship between conflict and the incidence of HIV/AIDS is complex. Still, compared to the situation ten years ago, much more information is now available to inform programmes.

A family planning session in Thailand

This chapter sketches the effects of conflict and displacement in five categories of reproductive health:

- fertility and family planning;
- sexually-transmitted infections, including HIV/AIDS;
- gender-based violence;
- safe motherhood, including emergency obstetric care; and
- adolescent reproductive health.

Fertility and family planning

Research into fertility, fertility preferences and contraceptive use reveal a mixed response to childbearing among those affected by war and displacement. Conflict and forced migration may increase fertility and childbearing through social pressure and a desire to replace children or adults lost to war. In one Sudanese refugee camp in Ethiopia, for example, monthly crude birth rates increased from around one to over four per 1,000 between 1993 and 1996 as the community sought to repopulate following a massacre.[23] In some circumstances, the specific political conditions of conflict may encourage high birth rates as a demographic weapon. The Israeli–Palestinian conflict, for example, is marked by overt pro-natalism in Palestinian and ultra-orthodox Jewish society, and this has been key to maintaining high fertility levels in these communities.[24]

Conversely, fertility may be depressed in conflict settings because conditions are not conducive to childbearing. In Sarajevo, for example, birth rates dropped in the mid-1990s from 10,000 prior to the Bosnian conflict to 2,000 during the war, largely as a result of marital separation and a doubling in the rate of elective abortions.[25] In contrast, conflict may have only a marginal effect on fertility. In Beirut, fertility levels do not seem to have been significantly affected by the civil war that wracked the city in the 1980s.[26] It is likely that the effects of conflict and forced migration on fertility are determined at least partly by the stage of the humanitarian crisis, and by the pre-existing level of fertility control practiced by the affected population.[27] So, for example, severe starvation in the crisis stage of an emergency would almost certainly result in low conception rates and thus reduced fertility, while moderate malnutrition in later stages of the crisis is unlikely to affect conception. In a population accustomed to good access to contraceptives or safe abortion, the absence of these services due to war or displacement may result in increased fertility.

In Angola in the 1990s, it appears that people in the most affected areas of the country were less likely to have children during periods of intense conflict (between 1992 and 1994), and more likely to do so during periods of relative calm (in 1991–92 and 1994–98).[28] In zones least affected by the conflict, there was little fluctuation. In Ethiopia, fertility rates in the 1970s remained high and relatively stable, though marked by periodic declines and rebounds in response to specific episodes of instability, violence or economic difficulty.[29] This implies that births were being delayed during uncertain periods, until such time as conditions improved. However, if people lose their belief that conditions will indeed improve, this may have a long-term depressive effect. Fertility rates in Ethiopia began to decline steadily from 1982 with no

rebound to the high levels of earlier years. During this period, it seems that couples gave up on the notion that their circumstances would improve, and accepted protracted civil war and deteriorating economic conditions as standard elements of life. In Angola two years after hostilities ended, women in the areas that had been most affected by the war were still significantly less likely to want to become pregnant in the next 12 months than women in less affected zones. It is likely that the effects of the recent war were short-term: women's longer-term desire to have additional children was unaffected.[30]

Displaced people's pre-existing social and economic position may be as significant an influence as the fact of displacement itself: age, education and asset ownership may all affect fertility decisions and the number of children desired more strongly than does migration status.[31] A comparison of fertility levels between two groups of Khmer refugees in Thailand in November 1979 found that birth and pregnancy rates differed by socio-economic and educational status.[32] The birth rate among the urban, economically better-off refugees was 55 per 1,000, a level similar to pre-war Kampuchea; birth rates among the rural, poorer refugees were markedly lower, at 13 per 1,000 and, though predicted to increase, were not expected to match those of better-off women. These low rates were put down to sub-fecundity due to severe malnutrition on arrival at the camp.

It appears that conflict-affected people's desire to use family planning services varies widely, just as it does among settled populations. Socio-demographic factors, such as age and parity (the number of children a woman has), socio-economic status, education and urban/rural residence influence fertility desires. Pre-existing levels of awareness and contraceptive use are also influential. Whether there is an independent effect of conflict, beyond the influences of these known variables, is not yet clear. We are thus not yet at a stage where we can make a conclusive determination as to the effects of conflict on fertility levels or trends. Such patterns may emerge more clearly as more work is done. Furthermore, most research and programming is focused on refugees in stable camp settings. The effect of conflict on fertility may be different in the emergency phase, for those not living in camps, for displaced people out of reach of the international agencies that provide the bulk of health and other services, and for the repatriated. However, one finding is clear from past research and programme experience: since some demand for family planning will exist in virtually every conflict-affected population, it is critical that good family planning services are readily available.

Sexually transmitted infections, including HIV/AIDS

There appears to be a complex relationship between conflict and people's vulnerability to sexually transmitted infections (STIs) and HIV/AIDS. Some of the likely outcomes of conflict – greater sexual violence or increased risky sexual activity, commercial sex, forced migration, psychological stress, the collapse of health services – would seem to imply a heightened risk of infection, and what data there are seem to support such an association.[34] Studies of rural displaced people in Mozambique, for example, found HIV prevalence rates of 3.4% in 1987 and 4.6% in 1990, both much higher than the 0.9% rate in the general adult population in 1987.[35] Out of 634 Afghan refugee women in Pakistan examined in a 1998 study, over a third had at least one reproductive tract infection (RTI) (candidiasis was the most common), but there were no cases of gonorrhoea.[36] Among Rwandan refugees in Tanzania, the number of people diagnosed with STIs increased from 20 to 250 per week following an 18-month STI/HIV prevention programme, though whether this reflected a dramatic increase in prevalence, greater competence in diagnosis or improved health-seeking behaviour is unclear.[37] In their study of the spread of HIV infection in Uganda in the 1980s, Smallman-Raynor and Cliff note the long-standing link between military personnel, commercial sex workers and STI prevalence, and conclude that 'the classic association of war and disease substantially accounts for the presently observed geographical distribution of reported AIDS cases in Uganda'.[38]

Forced migration often affects HIV prevalence through the mixing of populations with different prevalence levels. In Rwanda, for example, HIV prevalence in rural and urban areas in 1997 was the same – 11%. This contrasts with estimated pre-war prevalence rates of 1% in rural areas, and high rates in urban areas (more than 10% among pregnant women).[39] Seroprevalence among those who had lived in refugee camps in Tanzania or Zaire was 8.5%, six to eight times higher than the rates in the rural areas from which they came. The increase was even greater for displaced people who remained in Rwanda during the conflict: 17% of women who survived rape tested positive for HIV. Conversely, displaced populations do not always have higher rates of infection than local populations. In a comparison of two Mozambican refugee camps in

Box 3

STIs and affected communities

Affected communities themselves recognise the importance of STIs and their association with war and forced population movement. In one study of reproductive health in communities affected by armed conflict in southern Sudan in 1999, STIs were the most consistently mentioned reproductive health problem among all groups. Health facility statistics confirmed the importance of STIs: with 13% of consultations, they were the fourth most common reason for attendance at the hospital. Community members attributed STIs to the 'movement of people and the war'.[33]

AIDS education officers in Sierra Leone

Swaziland, for example, prevalence rates were 10.8% in one camp, near Swaziland's two major cities, and 1.2% in an isolated camp in a sparsely populated area.[40] Greater contact between the refugees in the first camp and the Swazi population, which had an estimated seroprevalence of 18%, is a likely explanation.

Some characteristics of conflict may actually exert a protective influence on a population with regard to HIV transmission. For example, conflict may decrease the mobility and accessibility of some populations by destroying or cutting off roads or making travel insecure. Where pre-war HIV prevalence is low, the isolation of these populations may protect them from exposure. In Sierra Leone and southern Sudan, both of which have suffered years of war and apparently high levels of sexual violence, prevalence rates have been found to be surprisingly low: 0.9% in Sierra Leone[41] and 1–3% in Yei and Rumbek counties in southern Sudan.[42] Despite reportedly high rates of sexual violence, especially in Sierra Leone, low initial prevalence rates, combined with the inaccessibility of much of the population, may have slowed the spread of AIDS. Similarly, HIV prevalence rates appear to be lower in Angola than in surrounding countries: seropositivity estimates of 5–10% in Luanda and 1–4% in rural areas compared with estimates of 15–20% in the DRC, Zambia and Namibia.[43] As in Sierra Leone and Sudan, low initial prevalence rates and inaccessibility may have kept prevalence low in Angola's rural areas. The end of the conflict in Angola may in fact do more to increase the risk of HIV transmission than the conflict itself, as refugees return from camps in areas where prevalence rates are higher. Similar concerns have been expressed about the situation in southern Sudan.

The interaction of many related and competing factors may affect prevalence rates more than exposure to conflict itself. Evidence indicates that military presence is likely to promote transmission as STI rates tend to be higher among military as against civilian populations.[44] The presence of gender-based violence, both sexual violence and the use of sex for survival, also contributes to higher transmission risks.[45] The displacement that accompanies conflict promotes the intermixing of populations, which can lead to increased infection when high-prevalence and low-prevalence populations mingle. However, protracted conflicts may also isolate communities, limiting the mobility of their residents as well as making it more difficult for outsiders to enter. If these isolated communities had low initial HIV rates – as would be the case where conflict and isolation began *before* the rapid rise in HIV infection – then the conflict may, in fact, serve as a barrier keeping infection out.[46]

Gender-based violence

Sexual violence has always been a part of war. During the Second World War, an estimated 100,000 to 200,000 Korean, Indonesian, Chinese and Filipino women were sexually enslaved by the Japanese; during the 1971 Bangladeshi war, between 250,000 and 400,000 women were raped by Pakistani soldiers; and over a third of Vietnamese women who fled their country by sea in 1985 were abducted and/or raped.[47]

Cultural, economic, legal and political factors may perpetuate sexual violence.[48] Many of these factors are relevant to conflict situations: the disruption of cultural norms and family structure; women's economic dependence on men; limited access to basic necessities; no formal and dependable options for legal redress and strong social pressure to maintain the status quo in the face of enemy attack. During periods of conflict, violence in the home may increase as men compensate for loss of control over their lives by exerting violent control at home. Gathering evidence on the interactions between conflict and gender-based violence is, however, particularly difficult. Most humanitarian agencies lack the qualitative or quantitative tools to assess or monitor gender-based violence; under-reporting is a common problem, partly because victims fear stigmatisation and retribution, and partly because, in situations of humanitarian concern, appropriate services to facilitate disclosure are usually lacking.[49] Another factor complicating efforts to gather

evidence of gender-based violence during wartime is that its manifestations – domestic violence, rape, female genital cutting, forced marriage, sexual trafficking or sexual abuse – may be as prevalent in women's and children's lives in peacetime as in war. Evidence indicates that gender-based violence transcends socio-economic status, race, gender and ethnicity. It has been estimated that at least one in three women worldwide has been 'beaten, coerced into sex, or otherwise abused in her lifetime'.[50]

During the 1990s, the issue of war-related rape attracted particular attention in the conflicts in the Great Lakes region of Africa and the former Yugoslavia. An estimated quarter to half a million girls and women were raped during the Rwanda conflict.[51] The local Rwandan NGO Association of Widows of the Genocide (Avega) reported in 1999 that 39% of the women it interviewed said that they had been raped. A study of a group of Burundian refugee women in Kibondo District, Tanzania, found that one in four had suffered rape, and that most attacks (68%) had taken place in or around the refugee camp in which they lived. The majority of perpetrators (59%) were other refugees.[52] During the Bosnian war in the mid-1990s, rape was used as a systematic strategy, primarily to demoralise and humiliate the Muslim community as part of the Serbs' campaign of ethnic cleansing; estimates of the number of women raped range from 14,000 to 50,000.[53] The rape of men has also been documented: of 6,000 concentration camp inmates in Sarajevo Canton, 80% of males reportedly suffered rape during their detention.[54] Similarly, in the Kosovo war, as many as 45,000 Kosovar Albanian women may have been raped between August 1998 and August 1999.[55] Sexual violence by Serb armed forces was interpreted by Kosovar refugees as either plunder – usually rape at checkpoints, after which the women were released – or as a 'concrete manifestation' of hate, intended as an attack on all Kosovars.[56]

Less is known about patterns of domestic violence, as distinct from rape, among war-affected populations. One survey in Kakuma refugee camp in Kenya in 1998 found that 57% of women and 76% of men believed that husbands had the right to beat their wives; 12% of women reported being beaten in the previous month.[57] A 2002 study of internally-displaced women in Sierra Leone found that over half of the women interviewed (61%) believed that a man was entitled to beat his wife when she disobeys, and 65% thought that wives were obliged to have sex with their husbands even when they did not want to.[58]

Safe motherhood

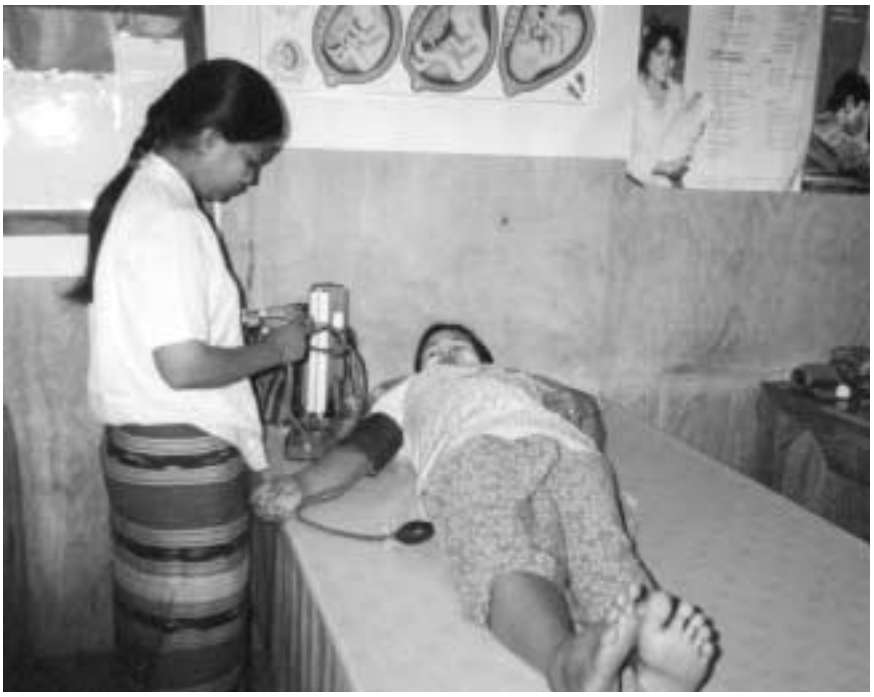
The majority of displaced women live in developing countries with some of the highest estimated maternal mortality ratios (MMRs) in the world. Thirteen of the lowest-ranking 20 countries in Save the Children's *Mothers Index* are either in conflict or emerging from it.[59] Many of the dangers women face in pregnancy are the same whether in or out of conflict, though war makes it more difficult for women and the health system to respond to these dangers.

In Ituri in eastern DRC, poor pregnancy outcomes (premature deliveries, stillbirths and spontaneous abortions) coincided with the onset of war in 1997 (11.4%) and rebel movements in 1999 (11.2%) and 2001 (11.5%).[61] A mortality survey of 20 health zones in eastern DRC found that known pregnancies in rebel-controlled eastern areas were three times more likely to end in spontaneous abortion or stillbirth than those in government-controlled areas in the west.[62] In 2000, a survey of over 4,000 households in Sierra Leone estimated a maternal mortality ratio of 1,800 maternal deaths per 100,000 live births (within a margin of error of 800 deaths).[63] In Afghanistan's Herat province, a study in 2002 suggested an MMR of 593 maternal deaths per 100,000 live births, with 92% of maternal deaths reported in rural areas.[64] Another 2002 study in Afghanistan found MMRs ranging from 400 in Kabul to 6,500 in remote Badakshan, and estimated an MMR of 1,600 for the country as a whole.[65] This far surpassed reported MMRs of all of the six countries bordering Afghanistan (Pakistan: 200; Iran: 60; Turkmenistan: 65; Uzbekistan: 60; China: 60; Tajikistan: 120). In Sarajevo, perinatal mortality (foetal deaths of at least 20 weeks' gestation and neonatal deaths within the first 28 days of life) increased from 15.3 per 1,000 live births before the war to 38.6 per 1,000 during it, the proportion of low birth-weight infants from 5.3% to 12.8%, and congenital abnormalities from less than 1% to 3%.[66]

Box 4
Rape and war

The RHRC developed and field-tested a standardised survey instrument to measure the prevalence of gender-based violence in East Timor and Kosovo in 2002.[60] In East Timor, the researchers concluded that rates of intimate-partner violence reported during the year preceding the crisis and the year preceding the survey were not significantly different. In both East Timor and Kosovo, violence by perpetrators outside the family was significantly lower post-crisis, with a decrease in reported physical assaults from 24% beforehand to 6% afterwards (in East Timor), and from 26% to 1% (in Kosovo). Incidence of sexual assault by an outside perpetrator also decreased from 23% in East Timor and 22% in Kosovo before the crisis, to 10% in East Timor and 2% in Kosovo after the conflict ended. These data help target programming for local prevention and response to gender-based violence. They have already been used in East Timor, for example, to inform parliamentary discussions about legislation on domestic violence.

There is evidence to suggest that poor birth outcomes are also an important problem for women and their infants in refugee camps. A study of Burundian refugee women in Mtendeli camp in Tanzania in 1997–98 showed that more than one in five live births (22.4%) were low birthweight (<2,500g); foetal and neonatal death rates were very high at 45.6 and 29.3 per 1,000 live births.[67] First or second pregnancy, multiple episodes of malaria and prior high socio-economic status (since high-status women may have lacked necessary camp survival skills) were all associated with poor pregnancy outcomes. Overall, maternal and neonatal mortality represented 16% of all deaths recorded in the camp during this period, the third-highest cause of death. A study in selected camps in Pakistan in 1999–2000 indicated that maternal and neonatal deaths comprised 22% of all recorded deaths, more than any other category.[68] The majority (60%) of infants born to women who died of maternal causes were either stillborn or died soon after birth.



An antenatal visit in Thailand

The relative availability and use of health services often explains pregnancy outcomes. In the Pakistan study cited above, for example, women who died of maternal causes had considerably more barriers to healthcare than other women, and their deaths were more likely to be preventable than those of women who died of non-maternal causes. The increase in perinatal mortality observed in wartime Sarajevo has similarly been attributed to the difficulties in managing care because of damage to the health infrastructure. In the Herat case, fewer than 1% of respondents reported the presence of a trained healthcare worker at birth; 97% reported assistance by untrained traditional birth attendants. This suggests that differences in pregnancy-related outcomes are probably due more to the availability and use of services, rather than to displaced status *per se*.

The available data on maternal and pregnancy outcomes suggest that poor outcomes are common in many populations affected by armed conflict, especially in the emergency phase of a conflict and in countries where the infrastructure has been devastated by protracted warfare. However, these outcomes may be no more common than in extremely poor host or home countries with a dearth of infrastructure and services. Indeed, women in refugee camps may in fact receive better care than was available in their home country, or is available to the local population. Comparative health data across a range of African and Asian countries (see Box 5) suggest that maternal mortality ratios for some groups were lower in camps than in the country of origin, primarily because of better access

Box 5

A survey of maternal mortality in refugee and displaced settings

Between August 1998 and March 2000, researchers from the US Centers for Disease Control and Prevention undertook a retrospective study of reproductive health outcomes among 688,766 refugees and internally-displaced people in 52 post-emergency camps in seven countries: Azerbaijan (seven camps), Ethiopia (11 camps), Burma (three camps), Nepal (seven camps), Tanzania (eight camps), Thailand (five camps) and Uganda (11 camps).[69] The reproductive health outcomes of these refugee and displaced groups were compared with available data for reference populations within the host country and country of origin. Maternal mortality ratios, calculated for six groups in sub-Saharan Africa, were lower in four of the six groups than in their country of origin, and lower in five of the six groups than in their host country. Access to emergency obstetric care was posited as the primary reason for these lower MMRs. All of the residents of the 52 camps in the study had access to healthcare at little or no cost; emergency obstetric services were available in referral hospitals within 12 hours; and in many cases NGOs provided free transport to the referral hospitals.

to emergency obstetric care. In one study area in Uganda, obstetric interventions for refugees were twice as common as for the rural host population.[70] Conversely, host populations may benefit from services developed for refugees. In a study in rural Guinea, where some 500,000 Liberian and Sierra Leonean refugees settled in the 1990s, rates of major obstetric interventions for the local Guinean population increased significantly in all settlement areas, and the largest increase (from 0.03% to 1.06%) occurred in the area with the greatest number of refugees.[71]

Spontaneous or unsafe induced abortion is a controversial subject, and little information is available on its incidence in conflict settings. What evidence there is suggests that it can be common: researchers have, for example, found the incidence of complications due to spontaneous or induced abortion in 34 camps in sub-Saharan Africa to be 54.6 per 1,000 live births.[72] In one study of Burmese women, involving a review of 400 medical records held by Thai and Burmese health facilities, complemented by interviews and focus groups, more than one in three reported inducing their own abortions using local medicine, sticks and pummelling of the pelvic area.[73] This high rate of induced abortion was put down to the limited range of family planning methods available, language barriers and a lack of knowledge about family planning on the part of the lay midwives to whom many Burmese women turn for advice.

Adolescent reproductive health

In conflict situations, adolescents have been described as the 'underserved of the underserved'.[74] Although younger children have been recognised as vulnerable and are the focus of specific programmes, this is less often the case for adolescents. Limited quantitative data have been collected on the reproductive health of adolescents in conflict settings, but what evidence there is suggests that the conditions they face are a danger to their overall health and social and economic development. Adolescent girls are more likely than younger girls to be sexually abused or abducted, and adolescents who are sexually active are at greater risk of contracting STIs, including HIV.

Research by the Women's Commission for Refugee Women and Children in Kosovo in 2000 identified STIs and unsafe abortion as major health risks facing adolescents, particularly girls; adolescent girls also expressed fears of being kidnapped by traffickers and forced into prostitution.[75] In northern Uganda, adolescent refugee and displaced girls told the Women's Commission that fear of sexual attacks severely restricted their movements, and identified 'rape and defilement' as one of their top five concerns.[76] (Thousands of girls had been abducted to provide sex or become 'wives' for rebel fighters.) In a study in northern and western Sierra Leone, the Women's Commission found that young women expressed continual fear of sexual violence, believing that the massive violence during the war had desensitised many people to it.[77] The exchange of sex for money or goods was found to be common; an overwhelming majority of the more than 600 Sierra Leonean adolescents interviewed stated that they could identify individuals involved in transactional sex, including themselves. Poverty was cited as the main reason for engaging in commercial sex. Another study reports similar findings in IDP camps in Freetown, Sierra Leone: adolescent women mentioned economic factors (food, money and goods) as a primary motivation to engage in sexual activity; this behaviour is reportedly deemed necessary for the survival of their families.[78] Many young women also expressed a fear of rape or coercion in sexual relationships.

Adolescents tend to have more restricted access than adults to information about reproductive health, and are less likely to access healthcare services.[79] In the Kosovo study cited above, for example, few adolescents accessed health services, and nearly all the young people interviewed reported having had little exposure to reproductive health information. Among the Freetown group, unplanned pregnancy was a major concern, condom use was reportedly low and young people generally did not see themselves at high risk of HIV infection. These findings were echoed in the other Sierra Leone study, which found limited knowledge of reproductive health issues, including a lack of awareness among adolescents about the reproductive health services available to them. Those who knew of the existence of these services believed them to be only for people who were married or older than themselves. The majority of adolescents did not use condoms, and as many as 85% of young people denied the existence of HIV/AIDS. Even where reproductive health information is available, its messages may not be effective: according to a study of birth patterns among young Congolese refugee women in Tanzania, the provision of family planning information to adolescent mothers after giving birth did not prevent them from falling pregnant again very quickly afterwards.[80]

The barriers to better health education and services for adolescents may be social, cultural or religious, or a combination of all three. In Kakuma refugee camp in Kenya, for instance, where sexually-active adolescents rarely used condoms, young refugees have reportedly faced social and religious opposition to their accessing reproductive health information and services.[81] In Kosovo, social stigma surrounding adolescent sex was reportedly very strong. In other circumstances, pregnancy may be actively sought: displaced adolescents in Barranquilla and Cartagena in Colombia, for example, reported seeking to become pregnant for the status it confers on them as well as for the comfort of having a child.[82] The same research found that adolescents were being exploited by their families and pushed into exchanging sex for money to increase family income. One in four adolescent girls had been pregnant, and one in ten reported being pregnant at the time of the survey. These rates were significantly higher than for Colombia overall.

Using research to inform programmes

We now have a good understanding of the magnitude of the reproductive health problems facing conflict-affected people in stable camp settings. Programme decisions once based on impressions and assumptions can now be grounded in solid findings from a broad range of studies, so that services respond to the real needs, interests and concerns of the displaced. Research priorities for programmes serving refugees in camps can now shift to operational research (often called applied or system research), a tool that can be used to determine how best to deliver good-quality reproductive health services.

There is still a need for descriptive and epidemiological research, however, particularly in non-camp settings. In the past decade, the imperative to serve all populations affected by armed conflict pushed some researchers towards non-camp populations, where they found reproductive health needs to be extreme. This suggests, and programme experience confirms, that there are important differences in health status and service environments between those in camp and non-camp settings. Understanding these differences and their implications for reproductive health service delivery requires the combined efforts of researchers and programmers.

Chapter 4

Reproductive health programmes for conflict-affected people

The number of programmes offering reproductive health services to those affected by armed conflict has increased substantially in the decade since the topic first attracted attention. An overview of the field produced in 1994 by the Women's Commission for Refugee Women and Children found virtually no reproductive health services and little awareness or interest in the topic among the humanitarian agencies serving refugees and displaced populations.[83] By 1998, a number of agencies were offering reproductive health services in the field – especially family planning and safe motherhood – and making the internal organisational changes required to position reproductive health as a standard component of their work with conflict-affected populations.[84] By 2004, the number of agencies providing reproductive health services had again increased, and the range of services had expanded to include, in some sites, gender-based violence, STI/HIV prevention and management and services designed specifically for adolescents.[85]

The scope and quality of reproductive health services

The scope of reproductive health services available to conflict-affected populations is without question better today than in the past. But substantial gaps in programme coverage, content and quality remain, making it difficult or impossible for affected populations actually to obtain reproductive health services. Problems include shortages of stocks; culturally inappropriate education and counselling; agency staff unable to speak the beneficiaries' language; and inadequate training and skills among staff tasked with providing services. These problems are not unique to conflict settings; many of them also plague reproductive health and other health programmes in stable sites. An assessment in Guinea, for example, noted that its health system, to which Liberian and Sierra Leonean refugees were referred, had only introduced reproductive health services several years earlier. It was a weak programme for all its users, not only for refugees.[89]

As with other services, refugees in camp settings are most likely to have access to reproductive health care, leaving displaced people and non-camp residents relatively worse off. Expediency and the concentration of organisations and staff make camps attractive sites for reproductive health service delivery at the outset. It is therefore not surprising that services are better established in refugee camps than in areas with dispersed and internally displaced populations. The situation of others affected by forced migration – repatriated refugees, conflict-affected people who could not leave or who chose to remain at home and host populations – is unclear.

Box 6

The state of reproductive health programming: a global survey

In 2003, the Inter-Agency Working Group on Reproductive Health in Refugee Settings undertook a global evaluation of reproductive health services for refugees and the internally displaced.[86] Researchers sent questionnaires to key informants in the 73 developing countries with at least 10,000 refugees or displaced persons, asking about the availability of reproductive health services for each refugee or displaced site or population concentration in their purview. One hundred and eighty-eight questionnaires were received from respondents in 33 countries in Africa, Asia and Latin America, covering a total population of approximately 8.5 million, most of them refugees living in stable camp settings.

The results showed that at least one component of antenatal care was available in all sites, and comprehensive antenatal care was offered in a third of sites.[87] Basic and comprehensive emergency obstetric care or referral were available in 45% and 39% of sites respectively. All elements of newborn care were available in 79% of sites.[88] Except for a handful of sites in Afghanistan and Pakistan, all reported offering at least one family planning method, with oral contraceptive pills (96%), condoms (95%) and injectables (89%) the most common methods. Community-based HIV and STI education was reported in 89% of sites, and STI diagnosis and treatment in 84%. Voluntary HIV counselling and testing, prevention of maternal-to-child HIV transmission and anti-retroviral therapy were considerably more limited, offered in just 35%, 20% and 6% of sites respectively. Programmes addressing gender-based violence were offered in more than half of the sites responding to the survey. Community education and psychosocial support to survivors were common, and offered in 79% and 64% of sites. Emergency contraception was available to survivors of rape in 60% of sites, an improvement over the results of a similar investigation in 1998. More than two-thirds of sites (70%) reported providing information and education about reproductive health and sexuality to adolescents.

There are substantial inherent challenges in providing services during the early emergency phase. The Minimum Initial Service Package (MISP) and the revised Sphere standards require selected reproductive health services to be available in the earliest phase.[90] A review of MISP implementation in 2003 has shown that, of 33 sites, at least one MISP component was in place within one month of the crisis in three-quarters of sites, and that all MISP components had been implemented within three months in approximately half of the sites.[91] Thus, many refugees and internally displaced people in the acute phase of humanitarian emergencies do not have adequate access to reproductive health services.

The scope and quality of services vary across regions and according to levels of general economic development.

Box 7

Reproductive health for conflict-affected people: five programme examples

Preventing HIV/AIDS in a post-conflict setting: ARC International, Sierra Leone

The American Refugee Committee (ARC) International began its programme to reduce the spread of STIs, including HIV, in the Port Loko district of Sierra Leone in December 2000. The programme targets several groups considered to be high risk, including military and police personnel, commercial sex workers and adolescents. ARC teams conducted intensive education sessions with the target groups about the risks of HIV and other STIs; the importance of practicing safe sex; and the need to recognise signs of STIs and seek appropriate treatment. In partnership with the Marie Stopes Society of Sierra Leone and the Ministry of Health and Sanitation, ARC provided local health workers with refresher training on the diagnosis and treatment of STIs. Free condoms were distributed at the ARC office, and in bars, barracks and other locations around Port Loko. In addition, ARC linked its micro-credit and AIDS prevention programmes to provide alternative economic opportunities to women wanting to leave commercial sex work. Finally, ARC conducted community activities, such as a festive parade through the town on World AIDS Day, during which condoms and educational brochures were distributed, and sporting events were held to involve the community in the project.

Baseline and post-intervention surveys of the target groups' knowledge, attitudes and behaviour regarding HIV/AIDS and other STIs showed dramatic improvements. For example, reported condom use among commercial sex workers increased from 38% to 68%, and among military personnel from 39% to 68%. A key element of the project that may have contributed to its success in achieving behaviour change was the focus on both commercial sex workers and their primary clients (in this case, military personnel). Based on its success in Port Loko, ARC has extended the project to other areas in northern Sierra Leone.[92]

Meeting the reproductive health needs of displaced adolescents: Profamilia Colombia

In January 2000, just under half (48%) of the displaced population in Colombia was under 18 years of age. To meet their sexual and reproductive health needs, Profamilia Colombia (the Colombian affiliate of the International Planned Parenthood Federation) in collaboration with Marie Stopes International implemented a two and a half-year project providing sexual and reproductive health services and information to displaced 15–19-year-olds in the peri-urban districts of Barranquilla and Cartagena, on Colombia's north coast. The project carried out activities including community education, peer-promoter training workshops and peer-led workshops for adolescents. Adolescents were welcome at the Profamilia clinics in Barranquilla and Cartagena, where family planning, gynaecology, general medicine and prenatal care were available to them. The project also held workshops for parents in the community to address their concerns and interests.

The end-of-project evaluation showed increases in knowledge and a shift in attitudes. Knowledge of contraceptive methods such as condoms, pills and injectables improved, and adolescents also became more knowledgeable about sources of information and services. There was also an increase in the level of understanding of sexual and reproductive rights. However, no change in contraceptive prevalence was found – it was measured at 14% in both baseline and post-project surveys. This may be because the project did not last long enough for a change in behaviour to be observed, or because barriers to care had not been adequately overcome.[93]

Improving family planning: International Medical Corps, Angola

In 2000, International Medical Corps (IMC) launched a family planning project in Huambo province, Angola. Huambo, site of the rebel group UNITA's headquarters, suffered some of the heaviest fighting during the country's civil war, and hosted some of its largest IDP populations. The conflict destroyed much of the provincial infrastructure.

IMC's project focused on improving the delivery of family planning services, increasing knowledge about them and increasing the use of family planning and other

Regions with well-functioning health and other systems at the start of a crisis – such as eastern Europe, Latin America and some countries in Asia – are better able to withstand the effects of conflict on these systems. They can deliver more and better-quality services, even in war, than can countries without such a foundation. Thus, the conflict-affected in sub-Saharan Africa and parts of Asia such as Afghanistan face larger gaps in services than do those elsewhere, and may also have to contend with poorer-quality services. Yet even in countries with good general health systems, such as Sri Lanka and Colombia, the care available to displaced people can be sub-standard.

Gaps in service provision exist within as well as across settings. The most well-established reproductive health services in conflict settings are family planning, safe

reproductive health services among both men and women. Traditional birth attendants and facility-based service providers were trained as reproductive health 'technicians', and given supervision and support. Community health workers conducted education activities, including gatherings with live music and drama in local languages, and a radio programme broadcast six times a week. The project also involved church and community leaders.

Baseline and post-intervention surveys in April/May 2001 and May/June 2003 respectively showed significant improvements in knowledge of modern family planning methods, especially among women. Use of family planning among women increased from less than 3% to 11%. Clinic statistics also showed a steady increase in the number of women who came for family planning services, from an average of 34 in the first six months of the project to an average of 231 in the last six months.[94]

Post-abortion care for girls: Mae Tao Clinic, Thailand

Isolation, totalitarian rule and civil war in Burma have displaced hundreds of thousands of women, men and children. In 2000, there were approximately one million internally displaced people inside the country, 120,000 Burmese refugees housed in camps along the Thai–Burma border and one million illegal migrants in Thailand, including 150,000 in the Mae Sot area, living in sub-standard conditions as workers in factories, farms, restaurants and brothels, or as domestics in private homes. Their security is extremely tenuous, and young Burmese women are subject to sexual exploitation. The consequences to their reproductive health are severe, including exposure to HIV/AIDS, Hepatitis B and other STIs, as well as to unwanted pregnancies, unsafe abortions and life-threatening obstetric complications.

The Mae Tao Clinic in Mae Sot runs a Reproductive Health Quality Improvement Project, supported by the Women's Commission for Refugee Women and Children. As part of the project, clinic staff received training in safer post-abortion care (complications from abortion are among the highest priority reproductive health problems facing women attending the Mae Tao Clinic). Staff are now able to assist women with safer procedures to reduce bleeding and infection following incomplete abortion. As part of their post-abortion care, women receive good-quality family planning counselling to reduce the need for risky illegal abortions. In addition, the clinic has established an outreach programme to educate women on how to avoid pregnancy, and how to access reproductive health care at the Clinic.[95]

Preventing maternal death in a conflict setting: ARC International, Liberia

In 2001, it seemed that conflict was subsiding in Liberia. Relief personnel were able to travel to almost all regions of the country, and commerce had resumed in most areas. During this period, the American Refugee Committee (ARC) set out to strengthen family planning and improve emergency obstetric care in Montserrado, Grand Gedeh and Sinoe Counties. Two grants to the Reproductive Health Response in Conflict Consortium allowed ARC to procure and supply obstetric equipment and drugs, recruit and train national staff and upgrade three hospitals to provide comprehensive obstetric care, and six health centres to provide basic emergency obstetric care. In addition, ARC employed a Nigerian surgeon to work at the remote Grand Gedeh County Hospital, and trained surgical technicians. The surgeon performed an average of three Caesarian sections per month, saving the lives of women who otherwise would certainly have died. Local project costs were less than $1,000 per month.

Hopes of peace in 2001 were short-lived, and fighting resurged throughout Liberia. Half of all Liberians were displaced to the greater Monrovia area before a glimmer of peace was again seen in 2003. In early 2004, Grand Gedeh County remained too insecure for the resumption of humanitarian assistance, and women were again without emergency obstetric care.[96]

motherhood and condom distribution.[97] These elements were introduced first, and were guided by extensive experience in development programming. Newer, less familiar services, including the prevention of and response to gender-based violence and HIV/AIDS services other than condom distribution, are not yet routinely available. Access to services within sites also differs for specific population sub-groups. Adolescents are recognised as a group in need of focused intervention, yet youth-friendly reproductive health services after school or work hours are not routinely available.[98] Men have often been left out of MCH-based reproductive health care; reaching them requires different and complementary service delivery strategies.[99]

The programme reviews and assessments of reproductive health services for conflict-affected populations are cause for optimism: refugees and displaced people today have choices not available a decade ago. Yet there are substantial gaps in reproductive health care, in where services are offered, which services are offered, to whom, and of what quality.

Filling the gaps in reproductive health programmes for the conflict-affected

In October 2003, staff from some 50 field sites described their programmes and findings in a conference in Brussels dedicated to reproductive health among conflict-affected populations.[100] Presenters discussed programmes that serve refugees and displaced populations, providing family planning, HIV education and condoms, STI prevention and treatment, gender-based violence counselling and support and care for pregnant women, including emergency obstetric care. In January 2004, the journal *Forced Migration Review* published a special issue highlighting reproductive health programmes serving refugees and displaced people.[101] The issue included descriptions of programmes in Colombia, on the Mexico–Guatemala border, in Sierra Leone, Tanzania, Uganda, Yemen and Afghanistan, and on the Thai–Burma border. These programmes addressed safe motherhood, HIV prevention, gender-based violence, family planning and adolescent sexuality.

While the programmes presented at the Brussels conference and described in *Forced Migration Review* are specific to the context of the population they serve, and identify their successes and challenges relevant to that context, a broad conclusion may be drawn from these programme experiences, as well as others available in the published literature and on organisations' websites. This is that people affected by armed conflict will use reproductive health services that are of good quality and offered to them in a manner that is respectful and appropriate. The challenge for the future, then, is to fill the current gaps in the scope, quality and content of reproductive health services.

The existence of strong policies is an important first step to developing good service programmes. Existing laws, policies, guidelines and standards deliver a clear message about the importance of reproductive health in every phase of humanitarian emergencies. Some NGOs have expressed their commitment to reproductive health by articulating organisational policies, while others have incorporated reproductive health into their primary health care policies or missions. These various policies and documents regarding reproductive health are important in their own right, and also serve as advocacy tools with donors and within NGOs to provide the necessary financial and organisational support to undertake reproductive health activities.

Another prerequisite to good service programmes is adequate funding. If resources for broad-based reproductive health programmes for refugees and the displaced decline, the field will be hard-pressed to expand and improve services to fill current service gaps. It will therefore be important to tap into non-traditional sources of funds, such as the Global Fund for AIDS, Tuberculosis and Malaria and AIDS-specific resources such as the US President's Emergency Plan for AIDS Relief (PEPFAR). Here, too, advocacy is critical. Externally, donors, national governments and development actors, in the face of already overwhelming need – particularly as AIDS takes its toll in sub-Saharan Africa and Asia – may not identify refugees or the displaced as important groups to include in their planning processes. Within the humanitarian community, new donors, funding sources and mechanisms will require NGOs to adapt, a process that may be difficult in the rapid-response environment of relief work. Given the protracted nature of many humanitarian situations and the often intensive interaction between the displaced and local populations, the short-term funding cycles common in relief settings hinder such efforts. Thus, advocacy and communication within and beyond the humanitarian community will be necessary if conflict-affected populations are to remain on the world's reproductive health agenda.

Gaps in good service delivery due to shortcomings in fundamental programme design and implementation can often be avoided or quickly addressed through good planning and management. While recognising the real difficulties of running service programmes in tense, complex conflict situations – including the problems posed by short-term, sporadic funding – it is hard to defend problems such as persistent stock shortages and an absence of culturally appropriate education and counselling, at least in long-term stable settings. Once there has been sufficient time to understand the context and to establish relationships with the communities being served, such problems should arise only as rare exceptions, if at all. Another problem commonly reported in the assessments discussed earlier concerns staff who lack the skills they need to do their jobs well. This problem could be quickly addressed through structured training, a programme of self-study (using the training materials and guidelines that are now available), apprenticeship or other skill-enhancing mechanisms. Without these fundamental elements in place, a reproductive health programme cannot consistently deliver good-quality services.

An adolescent workshop in Colombia

Another skills-based problem, though rarely identified as one by service providers, concerns shortages of staff with adequate skills in programme monitoring and evaluation. Related to this is a lack of emphasis on collecting accurate data, sharing it with stakeholders and using it to improve services. Given the action-oriented outlook in field programmes, monthly data compilation is often done by rote and then dispatched to 'head office', which may or may not offer feedback. A more dynamic process, such as the one used in the RHRC Consortium's Monitoring and Evaluation Program,[102] sees agency staff and stakeholders participating in the design of the programme's monitoring and evaluation plan; collecting the data; interpreting the data relative to the programme's objectives and workplans; and jointly deciding what actions should be taken to improve the programme. This process requires skills which staff may not have, so training and technical support may be needed. Such an investment is another means of enhancing the quality of the services delivered.

Current evidence suggests that many reproductive health programmes are technically sound, but that they could go farther to fill programming gaps. Regarding family planning services, for example, it is clear from the studies cited earlier that many refugee and displaced women, men and adolescents are interested in learning about and using contraceptives. It is therefore an error to assume that they are not, or that their societies are too traditional to accept family planning. The best family planning programmes offer a wide range of temporary, long-term and permanent methods to meet the changing needs of women, men and adolescents as they move through their reproductive lives. Emergency contraception, female condoms and other relatively new methods should be among the options offered, and may need special attention when they are introduced since they are unfamiliar to many providers. Service delivery must take into account the physical and psychosocial trauma experienced by those affected by conflict, including the possibility that women who have experienced sexual violence may need particular attention and support to address their family planning needs.

The results of gender-based violence studies are still relatively new, and their implications for prevention and response programmes are not yet elaborated or fully tested. Nevertheless, it is clear that future programmes must address ongoing domestic and community gender-based violence among refugee and displaced populations, and not just the violence carried out by armed factions and strangers in acute conflict periods. Furthermore, the evidence from the pioneering research and fieldwork done on gender-based violence to date suggests that response must be multi-sectoral, involving the health sector as well as security programmes, the judicial system, the education sector, social services and income generation and livelihoods programmes. Gender-based violence prevention and response must be broad-based in order to meet the needs of women and young people.

To reduce maternal mortality and morbidity, a major cause of death to women in many resource-poor settings, global safe motherhood guidelines are clear on the need for women's access to good-quality emergency obstetric care for treatment of life-threatening complications. This is based on strong evidence that most life-threatening complications can neither be predicted nor prevented, but can be treated through emergency obstetric care.[103] Screening approaches in which providers try to identify women who are at 'high risk' and 'low risk' for obstetric complications may give women and providers a false sense of security since any pregnant woman, even one identified as 'low risk', may experience a life-threatening complication. Training of traditional birth attendants (TBAs) is also widely carried out with the stated intention of reducing maternal mortality. However, in the absence of an emergency obstetric care facility to which they can refer women with complications, TBAs are unable to address the principal causes of maternal death and disability. TBAs, including trained ones, are explicitly excluded from WHO's definition of skilled attendants at birth.[104] Thus, programmes depending on TBAs to reduce maternal mortality should be discouraged. Antenatal care is another component of safe motherhood for which technical evidence is often overlooked. Antenatal care as frequently delivered in conflict and development settings is typically limited to taking weight and blood pressure;

performing a basic physical exam; providing tetanus toxoid and perhaps iron sulfate; and, ideally, treating illness. This does not, however, take full advantage of a pregnant woman's visit. For example, syphilis testing and treatment are inconsistently provided, but should be routine. Additional components of antenatal care recommended by WHO as directly reducing maternal death and disability include counselling on the danger signs of obstetric complications and assisting pregnant women to develop a birth preparedness plan. This encourages a woman to decide in advance where and with whom she will deliver; to have all the items she will need for safe delivery and immediate care of the newborn if she chooses to deliver at home; to understand the danger signs of complications she might suffer; to know when it is necessary to transfer to an emergency obstetric care facility; to decide in advance which facility she will go to if she experiences a complication; and to have a transport plan in place to reach the facility. Since household decision-making may require that others are involved in making women's birth preparedness plans, good antenatal care also requires that providers assist women to communicate with their husbands, in-laws and others who may influence decision-making.[105]

Health programmes addressing STIs including HIV/AIDS in conflict settings have largely focused on prevention using the 'ABC' approach: **A**bstain, **B**e Faithful and Use **C**ondoms. Some programmes also offer diagnosis and treatment of sexually transmitted infections, a service which should be routine in all programmes, and which should be heavily promoted to men, women and adolescents. Clinic-based programmes must adhere to universal precautions and ensure a safe blood supply. Additional interventions are now available, and have been shown to be effective in reducing the transmission of HIV and/or morbidity associated with AIDS. These include voluntary HIV/AIDS counselling and testing; the prevention of maternal to child transmission of HIV through targeted use of anti-retroviral therapy among HIV-positive pregnant women and their newborns; anti-retroviral therapy for HIV-positive individuals in the population at large; and community-based care for people living with AIDS. Yet few refugees or internally displaced people have access to these services, even as they are becoming more widely available to non-displaced populations. In addition to expanding the scope of services to include these options, programmes serving conflict-affected populations must use current evidence regarding the efficacy of focusing efforts on specific population sub-groups. For example, in populations with a relatively low prevalence of HIV (considered to be under 1%), infection is often concentrated in groups with particular profiles. In conflict and post-conflict settings, these may include the military and ex-combatants, commercial sex workers, transport workers and young women forced into transactional sex for survival. As HIV prevalence increases, it spreads into the broader population. Thus, programmes should use intervention strategies relevant to their particular setting and stage of the HIV pandemic, and incorporate the HIV/AIDS response into the overall emergency response. A multi-sectoral approach, involving protection, water and sanitation, food security, site planning and education as well as health, is required. The IASC *Guidelines for HIV/AIDS Intervention in Emergency Settings* can help agencies to deliver the minimum required multi-sectoral response in the early phase of an emergency, and offers guidance for a comprehensive response to HIV/AIDS.[106] Since social and economic ties, including sexual relations, between refugees or displaced and local populations are often active, HIV prevention and management programmes should not limit themselves to one or the other group. As peace and stability return to post-conflict settings, people may safely travel again for private or commercial purposes. While this is a positive development from many perspectives, it may also promote HIV transmission by exposing previously isolated people to new social and sexual networks.[107] Greater mobility may lead to the greater mixing of low- and high-prevalence populations, implying that programmes need to be adjusted accordingly.

Displaced and refugee adolescents also need options for obtaining good-quality family planning services; gender-based violence services and support; antenatal, delivery and emergency obstetric care; and STI/HIV/AIDS prevention, treatment and care. Services designed for adults may not fully meet adolescents' needs. Developmentally, socially and culturally, adolescents face different concerns and have different roles, responsibilities and expectations than do adults and children. Nor do 'adolescents' comprise one single group. Young women typically have different needs and concerns from those of young men. Older adolescents (for example, 18 years and above) have markedly different reproductive health needs than very young adolescents (12–14 year-olds) and the middle group (15–17-year olds). (These age groupings are offered as examples only since the roles and expectations of young people vary across cultures.) In conflict settings, young women and girls are often targets of gender-based violence, and young men and boys (and women and girls in some cases) may be pressed into military service. The long-term implications of these experiences on the mental and physical health of young people are not known, but reproductive health programmes should be sensitive to their potentially harmful effects. Adolescents should to the extent possible be involved in programme development and implementation; it is often important also to involve parents so that they do not prevent their sons and daughters from participating. Services to adolescents must be provided in a manner that is respectful and non-judgmental. It is poor public health practice, for example, to deny sexually-active adolescents access to the family planning services that would allow them to prevent unwanted pregnancies or STI/HIV transmission. Adolescents should receive comprehensive information that allows them to make informed choices about their reproductive and sexual health.

In the first decade of offering reproductive health services to conflict-affected people, those most likely to be reached were refugees living in stable camp settings. This response

was both understandable and an appropriate application of public health principles, since the relative ease of access, reasonable security conditions and existing service delivery mechanisms typically present in established refugee camps meant that large numbers of people were able to benefit from programmes relatively quickly. These settings also made it feasible to carry out the monitoring and evaluation activities that are needed in service delivery programmes, particularly when programmes are new and the evidence base is limited.

As we move into the second decade of promoting the reproductive health of conflict-affected people, this focus will need to broaden. Internally displaced people are often very difficult to reach, not least because they remain subject to governments or local power structures which may be the very cause of their displacement and suffering. Another group that rarely receives adequate care are those who cannot or will not leave their homes, but who suffer much of the same deprivation and anguish that internally displaced people and refugees experience. Neither of these groups has the recognised legal status of refugees since they do not cross an international border; this distinction may limit the services for which they are eligible. Host populations living near refugee camps have received more attention over the past decade. Because camps are often in poor regions of poor countries, their needs are often as great as those of refugees, though they may not have experienced the trauma of war. These groups deserve more attention, and the principle of equity demands that they receive it. The obligation is enormous: we must provide more and better reproductive health services to larger and more diverse groups of conflict-affected people.

Chapter 5
Conclusions

This review of policies, research and programmes related to the reproductive health of conflict-affected people shows that important changes for the better have occurred since attention was first paid to the topic in the mid-1990s, and since HPN last published a review of this area in 1998.[108]

Humanitarian policy around the reproductive health of people affected by conflict has evolved from virtually nil to normative status since the mid-1990s, a remarkable advance. Policies and guidelines at international, national and agency levels are important in their own right as demonstrations of commitment and intent. They are also important tools for advocacy both within the humanitarian and reproductive health fields and with other sectors and donors, an application that may become more valuable in the face of rising political and social conservatism, particularly in the US. While policies and guidelines alone are not sufficient to create change in the lives of conflict-affected people, the policy developments of the last decade have helped create momentum for research and service programmes.

Progress in the field has also caused research priorities to shift. Research needs for reproductive health within humanitarian response were discussed at a September 1998 meeting of some 40 representatives of research, service, policy and donor agencies involved in humanitarian issues.[109] The research needs identified as having the highest priority focused on the basic epidemiology of reproductive health among forced migrants. The group recommended investigating, for example, the prevalence of gender-based violence; the disease burden among pregnant women and infants; and the prevalence and transmission patterns of HIV. By the October 2003 meeting of the Inter-agency Working Group on Reproductive Health in Refugee Settings, the greater availability of data from the field permitted a shift in the research agenda.[110] This meeting identified operational research as the priority, focusing on questions of how best to deliver reproductive health services well and equitably. Descriptive and epidemiological research will still be needed, particularly to better understand the reproductive health status of conflict-affected people in non-camp settings, but the balance should shift in future towards greater applied research.

Service programmes providing reproductive health to conflict-affected women, men and adolescents now have a solid foundation on which to build. Bridging the existing gaps in the coverage, content and quality of services will require a greater reliance on evidence and experience to enable the design of technically and culturally sound programmes; good training and technical support; good management so that staffing, logistics, financial and related programme elements run smoothly; and good monitoring and evaluation systems, so that stakeholders can follow the progress of activities and intervene to improve them. Of paramount importance is the need for future policy, research and service programmes to address the issue of equity between refugees and the internally displaced, forced migrants and host populations, men and women, adults and adolescents.

Doing more of what was done in the past, even if we do it better, will not be enough. Future programmes to address the needs of refugees and internally displaced people must coherently address global health concerns such as AIDS, which respects neither boundaries nor neat social categories such as 'refugee' or 'local resident'. Future programmes must also assimilate new mechanisms for multilateral and bilateral cooperation, such as the Global Fund for AIDS, Tuberculosis and Malaria and the PEPFAR. These are 'development' rather than 'relief' initiatives, and cooperation between these two arms of global assistance has traditionally been limited. However, the protracted nature of many conflict settings and the strong social and economic ties that often develop among groups living in proximity render such distinctions increasingly less useful. UNHCR has called for refugees to be included in development assistance as well as in national HIV/AIDS programmes, and has proposed a 'Framework for Durable Solutions' to better target development assistance to countries and areas hosting large numbers of refugees.[111]

The world's conflict-affected people have more and better sexual and reproductive health services with which to make choices about their lives. Creative approaches and new partnerships will be required in future to maintain the momentum within this field. At the same time, continued diligence is needed to prevent the erosion of reproductive health issues in the face of shifting political, financial and health priorities. An essential component of this is holding the humanitarian system to account for its obligation to support the reproductive health and human rights of women, men and adolescents affected by conflict. Those whose lives have been forever touched by armed conflict deserve no less.

Annex

Reproductive health guidelines for programmes serving conflict-affected populations

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Network Papers

Network Papers are contributions on specific experiences or issues prepared either by HPN members or contributing specialists.

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18 *Beyond Working in Conflict: Understanding Conflict and Building Peace (The CODEP Workshop Report)*, by J. Bennett and M. Kayitesi Blewitt (1996)
19 *Human Rights and International Legal Standards: what relief workers need to know* by J. Darcy (1997)
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Good Practice Reviews

Good Practice Reviews are major, peer-reviewed contributions to humanitarian practice. They are produced periodically.

1 *Water and Sanitation in Emergencies* by A. Chalinder (1994)
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4 *Seed Provision During and After Emergencies* by the ODI Seeds and Biodiversity Programme (1996)
5 *Counting and Identification of Beneficiary Populations in Emergency Operations: Registration and its Alternatives* by J. Telford (1997)
6 *Temporary Human Settlement Planning for Displaced Populations in Emergencies* by A. Chalinder (1998)
7 *The Evaluation of Humanitarian Assistance Programmes in Complex Emergencies* by A. Hallam (1998)
8 *Operational Security Management in Violent Environments* by K. Van Brabant (2000)
9 *Disaster Risk Reduction: Mitigation and Preparedness in Development and Emergency Programming* by John Twigg (2004)

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HPN's aim is to improve the performance of humanitarian action by contributing to individual and institutional learning.

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